Developmental & Assistive Therapy Service Documentation Log

Student Information

Name: Jane Doe **Date of Birth (Mo/Day/Year):** 2/1/97

Diagnostic Code: 315.9

Provider Information

Provider Name: John Smith **Provider Title:** paraprofessional

Supervisory Union: Vermont SU **Name of School:** Vermont Elementary

IEP Service:

List the activity being provided as it appears on the IEP.

IEP Activity	Individual or Group	Minutes Per Session	Sessions Per Week	Hours Per Week
Reading Skills	**I**	**1hr**	**3**	**3**

Developmental & Assistive Therapy service listed above was provided to this student as shown in the calendar below:

Service Dates: The numbered boxes below reflect the days of the month. Enter month and year for the month(s) of billing period. Mark an "X" for each day that the Developmental and Assistive Therapy service was provided for the minutes and group size listed above. **If the minutes per session or group size are different then what is listed above, the actual minutes per session or group size should be indicated on the calendar**. For services provided in groups, only include those provided in Medicaid billable group size. For professionals, the group size must be six or less students and for paraprofessionals, the group size must be four or less students.
DO NOT USE PENCIL OR WHITE OUT.

Month October Year 2006 Month _____ Year _____

Use this set of dates for a two-month billing period

1	2 X	3	4 X	5	6 X	7	1	2	3	4	5	6	7
8	9 30m	10	11 X	12	13 X	14	8	9	10	11	12	13	14
15	16 30m	17	18 X	19	20 X	21	15	16	17	18	19	20	21
22	23 30m	24	25 X	26	27 X	28	22	23	24	25	26	27	28
29	30 X	31					29	30	31				

Indicate the total number of hours of billable service provided during the billing period:	**1:1 Service**	**11**	**Hours**
	Small Group		**Hours**

Provider Signature: ***John Smith*** **Date:** **11/2/06**

Supervisor Signature: **Jessica Hill** **Date:** **11/2/06**

Supervisor Name (Printed): _____